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ABSTRACT

This study examined and sought to clarify several major issues related to Adult Children of Alcoholics (ACA) and the notion that they are at increased risk for developing problems with alcohol. The study involved a questionnaire survey of randomly selected university counseling centers in regard to a variety of ACA issues. A total of 102 questionnaires were completed for a return rate of 51%. The questionnaire contained four sections requesting information on: ACA treatment opportunities on campus; information on ACA counseling staff; staff perceptions on the accuracy of Woititz's 13 ACA characteristics; and staff perceptions on the successfulness of their campus' ACA treatments. The study also examined the use of commercially prepared ACA workbooks, most of which contain Woititz's personality characteristics. As a result of the study, college students were identified as appropriate subjects for future ACA research. Counseling center group leaders were overwhelmingly supportive of using Woititz's characteristics and most of them noted that they started ACA groups because of staff interest. Regardless of interpretations of the study's findings, ACA group leaders on university campuses are not conducting their groups in ways consistent with recent research on ACAs. Further research is recommended. Five tables present questionnaire results. (Contains 29 references.) (KW)

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Group Leader Perceptions of ACA Characteristics

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The notion that children of alcoholics (COAs) are at increased risk for developing problems with alcohol themselves has been supported by a rather extensive literature. Some researchers have focused on the possibility that genetic factors are largely responsible for this increased risk (Cadoret, 1987; Cloninger, Bohman, & Sigvardson, 1981; Goodwin, 1976, 1979), while others have attempted to identify reliable markers that would explain this connection (Alterman, Bridges, & Tarter, 1985; Begleiter, Porjesz, Bihari, & Kissin, 1984; Elmasian, Neville, Woods, Schuckit, & Bloom, 1982; Gabrielli & Mednick, 1983; Schuckit, 1987). Biological, neuropsychological, electrophysiological, and psychological markers have been proposed, all with very limited success (for a comprehensive review, see Searles, 1988).

Woititz (1983) went well beyond the notion of markers and introduced the idea that adult children of alcoholics (ACAs) represent a homogeneous group of individuals described by 13 personality characteristics. She has claimed that ACAs: (1) guess at what normal behavior is; (2) have difficulty following projects through from beginning to end; (3) lie when it would be just as easy to tell the truth; (4) judge themselves without mercy; (5) have difficulty having fun; (6) take themselves very seriously; (7) have difficulty with intimate relationships; (8) overreact to changes over which they have no control; (9) constantly seek approval and affirmation; (10) usually feel that they are "different" from other people; (11) are super responsible or irresponsible; (12) are extremely loyal, even when loyalty is undeserved; and (13) are impulsive.

Despite early support for the idea that growing up in an alcoholic family produced specific effects on personality (Ackerman, 1983; Black, Bucky, & Wilder-Padilla, 1986; Moos & Billings, 1982; Wegscheider, 1981), recent research has not supported the

hypothesis of homogeneity (Alterman, Searles, & Hall, 1989; Clair & Genest, 1987; Lyon & Seefeldt, 1995; Mintz, Kashubeck, & Tracy, 1995; Seefeldt & Lyon, 1992; Venugopal, 1985). Recent models of ACA outcomes suggest the notion of homogeneity was oversimplistic, with several factors (beyond family history) involved in the development of problems with alcohol, or psychological problems in general. Sher, Walitzer, Wood, and Brent (1991) demonstrated empirical support for an outcome model in which behavioral undercontrol and alcohol expectancies played an intermediary role in subsequent alcohol involvement. Similarly, Seefeldt and Lyon (1994) developed a model which includes both psychological and sociocultural factors as hypothesized predictors of ACA outcomes.

In spite of this recent research, current publications such as *Changes: For and About Adult Children,* national conventions for ACAs, and advertisements for ACA groups which continue to use Woititz's (1983) characteristics as valid descriptors of ACAs, seem to suggest a growing division between research on ACA outcomes and the treatment of individuals who are identified as ACAs. This difference may be at least partially attributed to the general controversy over the value of research in the practice of psychotherapy (see Barlow, 1986; Meltzoff, 1984; Mindell, 1993; and Phillips, 1989, for recent discussions of this issue). More specifically, criticisms of this research have focused on the fact that many of the nonsupportive studies have used college students as subjects. According to Woititiz, college students are not good subjects for ACA studies because their maladaptive characteristics would only develop after leaving college and entering the "real world" (Meacham, 1991).

The present study was an attempt to clarify several major issues related to ACAs and their treatment in group settings. The first issue relates to the legitimacy of the use of

college students as subjects for ACA research. If ACAs cannot be identified until they are in the "real world," then few ACA groups should exist on university campuses. Thus, our primary purpose was to determine the prevalence of ACA groups on university campuses. In addition, we collected information about the professionals who offer such groups, their reasons for offering the groups, the kinds of materials they used, and whether they perceived their clients in a similar way as the ACAs described by Woititz.

Method

Respondents and Procedure

As mentioned earlier, a major purpose of this study was to survey University Counseling Centers about a variety of ACA issues. Initially, 4 universities or colleges from each state in the U.S. were randomly selected from state lists provided in *Peterson's Guide to Four-Year Colleges and Universities* (1991). Two-hundred questionnaires were then mailed to the Directors of the identified Counseling Centers. A total of 102 questionnaires were completed, for a return rate of 51%. All questionnaires returned were usable for data analysis, and responses were received from all regions of the U.S. in approximately equal proportions. No attempts were made to follow-up the initial mailing of 200 questionnaires or replace nonrespondents in the sample in any way.

Questionnaire

The questionnaire used in this study was designed by the authors and specifically intended to gather information about ACA treatment, and perceptions of treatment, on University campuses. It contained 4 sections. Section 1 requested information about whether ACA treatment was regularly provided in University Counseling Centers, the nature of these treatment(s), types of service delivery methods, and information about the

clients using such services. Section 2 requested information about the Counseling Center staff, their theoretical orientations, and level of training. Section 3 surveyed staff perceptions about the accuracy of Woititz's (1983) 13 ACA characteristics and their applicability to the college student population. Finally, Section 4 requested information about staff perceptions of the successfulness of their ACA treatment(s), as well as recommendations for alternative treatment(s) that were not currently being utilized.

Results

As reported earlier, 102 (51%) questionnaires were completed and returned. Of these, 51 (50%) reported that their University Counseling Center conducted ACA groups on a regular basis. There was, thus, a dichotomous representation of ACA treatments being provided by this sample of Counseling Centers; with half of the Universities reporting that such treatments were useful and productive of positive outcomes, and the other half reporting that such services were not provided at all. An analysis of open-ended comments on the surveys of Counseling Centers not providing ACA groups indicated that the primary reason for not doing so was skepticism about the veracity of the ACA label.

Table 1 provides information about the number of staff working with ACAs and their levels of training. As can be seen, an average of approximately 2 Counseling Center staff were reported as working with ACA groups on a regular basis. Typically, this included one doctoral and one masters level clinician. Only one Counseling Center reported that Bachelors level staff worked with ACA groups, and this included only one individual.

Table 2 provides frequencies for the primary theoretical orientations of Counseling Center staff. Eclectic and psychodynamic practitioners were most highly represented in

the current sample, with a moderate number of cognitive-behavioral, systems, and humanistic practitioners as well. Other theoretical orientations were less well represented among this sample of University Counseling Center staff.

Table 3 provides information about the characteristics of the ACA groups conducted and the clients who seek these services. On average, the Counseling Centers that conduct such groups have been doing so for approximately 4 years, and run between 2 and 3 groups per year. Between 3 and 15 clients (M = 7.86) were reported as participating in each group, and their typical duration was approximately 5 months. Additionally, a preponderance of female clients (M = 71.25%) were reported as participating in ACA groups, as well as traditional age college students (M = 62.5%).

A further issue we were interested in exploring was the use of commercially prepared ACA workbooks, almost all of which contain Woititz's (1983) 13 personality characteristics as one important frame of reference. About half (48.9%) of the Counseling Centers conducting ACA groups reported that they used such materials. Table 4 provides ratings by staff of the perceived accuracy and helpfulness of these materials. Only 48.6% of respondents indicated that they found workbook materials to be accurate or very accurate; yet 73.6% reported that they found them to be helpful or very helpful. We also inquired about how interest in conducting ACA groups originated. 77.1% of respondents indicated that it was staff interest which initiated these groups, and 22.9% reported it was primarily due to client demand.

Table 5 provides a summary of respondents' ratings of the descriptive accuracy of Woititz's characteristics for the ACA clients they serve. As can be seen, all but 3 characteristics (lie when it would be just as easy to tell the truth, difficulty folowing

through on tasks, and impulsive) were rated as appropriately descriptive of college-age clients participating in ACA groups. These data appear to contradict the claim of Woititz that such problems would not manifest themselves prominently among college-age students.

Finally, we asked respondents to estimate the percentage of clients participating in ACA groups who displayed positive outcomes as a result of treatment. Responses to this question ranged from 15 to 98%, with a mean percentage of 83.3. Hence, the vast majority of college-age ACA clients were seen as benefitting from treatment. We also asked respondents whether they felt alternative methods of treatment were needed to reach a broader constituency of ACA clients and 61.4% responded "yes." Primary suggestions for expanded treatment options fell into two distinct categories, with one group of respondents suggesting more AA approaches to treatment, and another group favoring more cognitive problem-solving approaches.

Discussion

The first purpose of our study was to determine the prevalence of ACA groups on college campuses. One-half (51) of the 102 college and university counseling centers returning the survey stated they currently had ACA groups on their campuses. In addition, over 60% of group members were traditional-aged college students. These findings clearly indicate that college campuses, and in particular college students, are appropriate for ACA research. Woititz's concern that college students are too young to be identified as experiencing this "syndrome" appears to be unnwarranted.

Another interesting finding was that an overwhelming majority of group leaders stated that ACA groups were started on their campuses because of the interest of staff members themselves. Only about one-fourth of group leaders stated that ACA groups were started because of client/student demand. In addition, group leaders were overwhelmingly supportive of Woititz's characteristics, and reported that workbooks designed to facilitiate these groups were very helpful. The fact that less than 50% of group leaders found the workbooks to be accurate or very accurate is a bit unsettling, since they are based to a large extent on Woititz's characteristics. One potential explanation for this is that once group leaders commit themselves to using the workbooks, cognitive dissonance creates a need to view them as helpful, if not totally accurate. Nevertheless, on the basis of this survey, ACA group leaders seem to believe that Woititz's descriptions are reasonably accurate.

Previous discussions of the ACA phenomenon have utilized the Barnum effect and illusory correlates to explain the popularity of Woititz's characteristics (Lyon & Seefeldt, 1995; Seefeldt & Lyon 1992; Sher, 1991). These constructs again seem germane in explaining the

results of the present study. It appears that an overwhelming number of ACA groups are initiated as a result of the interest of Counseling Center staff. Presumably, these staff members are aware of the popular literature on ACAs, and begin with the assumption that they are correct. After soliciting students to participate in the groups, it would not be difficult to "discover" such characteristics in their clients. As one group leader stated, "Some students come in and do not know that they possess these characteristics. An important part of the group process is teaching them that in fact they ***do*** have many of these problems." Barnum effects would also help explain the overwhelming support group leaders show for the descriptive validity of Woititz's characteristics. An alternative explanation, of course, would be that group leaders are simply very perceptive and intuitively able to pick out ACA characteristics that previous research studies have been unable to verify. Regardless of the correct interpretation, our data are clear in showing that ACA group leaders are not conducting their groups in ways consistent with recent research on ACAs. As mentioned in the introduction, this problem is not peculiar to ACAs, but rather is another example of the continuing differences between clinical practice and empirical research.

In conclusion, the results of this survey are troubling in that it appears research refuting the homogeneity of ACAs is not having an impact on the practice of ACA treatment on college campuses. Perhaps further research, or added incentives to communicate the results of this research, are necessary in order to increase congruence between ACA research and practice. When that happens, we can hopefully begin to address the more complex variables involved in the development of problems which are a partially influenced by having parents with drinking problems.

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Table 1

Counseling Center Staff and Levels of Training

Dimension	M	SD	Min-Max
Number of staff working with ACAs	2.33	1.45	0-8
Doctoral level staff	0.86	0.98	0-6
Masters level staff	0.88	0.95	0-6
Bachelors level staff	0.02	0.05	0-1

Table 2

Frequencies of Staff Members' Primary Theoretical Orientation

Orientation	Frequency
Psychodynamic	33
Behavioral	02
Cognitive	08
Cognitive-Behavioral	22
Systems	13
Biomedical	00
Humanistic	11
Alcoholics Anonymous	00
Eclectic	44

Table 3

Information on ACA Groups and Clients

Dimension	M	SD	Min-Max
Number of groups run per year	2.51	1.56	0-13
Years of running ACA groups	4.13	2.08	0-8
Number of clients in groups	7.86	2.59	3-15
Average length of groups (months)	5.36	3.29	1-18
% males in groups	28.75	10.63	0-60
% females in groups	71.25	13.98	40-98
% traditional age students in groups	62.50	17.34	5-98
% nontraditional age students in groups	37.50	12.45	0-90

Table 4

Ratings (in %) of Accuracy and Helpfulness of ACA Workbooks [a]

Dimension	1	2	3	4	5
How accurate ACA workbooks	5.7	5.7	40.0	25.7	22.9
How helpful ACA workbooks	0.0	5.9	20.6	47.1	26.5

1=very inaccurate/unhelpful 2=inaccurate/unhelpful 3=somewhat accurate/helpful 4=accurate/helpful 5=very accurate/helpful

[a] 48.9% of respondents reported using commercially prepared ACA workbooks

Table 5

Ratings (in %) of the Descriptiveness of Woititz's 13 ACA Characteristics

Characteristic	1	2	3	4	5
Judge self without mercy	44.4	24.4	28.9	2.2	0.0
Extremely loyal	25.0	29.5	36.4	9.1	0.0
Lie when just as easy to tell truth	6.8	11.4	38.6	29.5	13.6
Difficulty following through on tasks	8.9	26.7	37.8	17.8	8.9
Impulsive	11.4	20.5	40.9	27.3	0.0
Take self very seriously	46.7	40.0	8.9	4.4	0.0
Have difficulty having fun	37.8	33.3	24.4	4.4	0.0
Constantly seek approval	62.2	28.9	6.7	2.2	0.0
Super responsible or irresponsible	50.0	22.7	22.7	4.5	0.0
Have difficulty with intimate relationships	68.9	26.7	4.4	0.0	0.0
Guess at what normal behavior is	44.4	24.4	26.7	4.4	0.0
Overreact to changes which cannot control	27.5	25.5	25.5	5.9	2.0
Feel different from others	51.1	33.3	13.3	2.2	0.0

1= very much like my clients 2=like my clients 3=somewhat like my clients 4= unlike my clients

5 = very much unlike my clients